MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4586

CERTIFICATE OF DEATH

64539
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Gorman
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3 Mi. West Gorman

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland, b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Gorman
d. STREET ADDRESS: Post Office Bayard, W. Va.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Charles Middle Luther Last (or) Blamble
4. DATE OF DEATH: Month April Day 29, Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/30/1878
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Blamble
14. MOTHER'S MAIDEN NAME: Christina Knepp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Keith Blamble Address: Bayard, W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 2 years
450.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from FEBRUARY 22, 1951 to APRIL 29, 19 60, that I last saw the deceased alive on APRIL 27, 19 60, and that death occurred at 10:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew E Mance M.D. ADDRESS (Street, city or town, state): Oakland Md DATE SIGNED: 30/4/60

PHYSICIAN'S NAME (Type): Andrew E. Mance, M. D. Oakland, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/2/1960
22c. NAME OF CEMETERY OR CREMATORY: Red House Cemetery
22d. LOCATION (City, town, or county) (State): Garrett Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. E. Laughton ADDRESS: Oakland, Md.
24a. REC'D BY REGISTRAR DATE: MAY 3 '60
24b. REGISTRAR'S SIGNATURE: Andrew E Mance

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4587 Item 9 Film G262 5/4/60 iwk

CERTIFICATE OF DEATH

64540 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Allegany Garrett MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park
c. LENGTH OF STAY IN 1b 2 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bowser Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport, Maryland
d. STREET ADDRESS R.D.1 Westernport
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Fannie Middle: Belinda Last: Blizzard

4. DATE OF DEATH Month: April Day: 24 Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 4, 1896
9. AGE (In years last birthday): 63/64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Jonathan Blizzard
14. MOTHER'S MAIDEN NAME: Margaret R. Van Meter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ernest Blizzard Address: Deer Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrage with Left sided
DUE TO (b) Paralysis
DUE TO (c) Hypertension

INTERVAL BETWEEN ONSET AND DEATH: (a) minutes; (b); (c) 5 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 1, 1960, to April 24, 1960, that I last saw the deceased alive on April 24, 1960, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE Ralph Calandrella M.D. ADDRESS (Street, city or town, state) Kitzmiller, Md DATE SIGNED 4/26/60

PHYSICIAN'S NAME (Type) RALPH CALANDRELLA Kitzmiller MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/27/60
22c. NAME OF CEMETERY OR CREMATORY: Philos
22d. LOCATION (City, town, or county) (State): Westernport, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: E.L. Bond ADDRESS: Westernport, Md.
24a. REC'D BY REGISTRAR DATE APR 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4588 Item 1 FilmG265 6-23-60 et

CERTIFICATE OF DEATH

06321 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Ga rrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Grantsville
c. LENGTH OF STAY IN 1b: 3 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): (Private home) R.F.D.# 2, Grantsville, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna.
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural,- Meyersdale, Pa. 75x-3
d. STREET ADDRESS: R.F.D.# 1, Meyersdale, Pa.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Myrtle; Middle: (Lindeman); Last: Buterbaugh

4. DATE OF DEATH: Month: April; Day: 4; Year: 1960

5. SEX: Fem.

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 5,1896

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sewing Mach.Oporator

10b. KIND OF BUSINESS OR INDUSTRY: Shirt Factory

11. BIRTHPLACE (State or foreign country): Somerset Co., Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Perry Lindeman

14. MOTHER'S MAIDEN NAME: Ellen Weller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -----

16. SOCIAL SECURITY NO.: 198-20-1801

INFORMANT: Albert Buterbaugh, Address: R.D.#1, Meyersdale, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Carcinomatosis
DUE TO (b): Carcinoma right Breast
DUE TO (c):

170X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/2, 1960, to 4/4, 1960 that I last saw the deceased alive on 4/2, 1960, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C O Glassmn M.D.

ADDRESS (Street, city or town, state): 345 Main St Meyersdale Pa

DATE SIGNED: 4/6-60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Apr.7,1960

22c. NAME OF CEMETERY OR CREMATORY: Lichty Cemetery

22d. LOCATION (City, town, or county) (State): R.F.D.# 1, Meyersdale, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: H. R. Kantner

ADDRESS: Meyersdale, Pa.

24a. REC'D BY REGISTRAR DATE: JUN 16 '60

24b. REGISTRAR'S SIGNATURE: Arthur S Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4578 **CERTIFICATE OF DEATH** 64541

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b: 9 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Garrett County Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY: Tucker
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Albert 85X-3
d. STREET ADDRESS: Box #24
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First John; Middle; Last Crawford

4. DATE OF DEATH: Month April; Day 19; Year 1960

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 26, 1877

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: soft coal mining

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Joe Crawford

14. MOTHER'S MAIDEN NAME: (Unknown) Lasbaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 232-03-1021

17. INFORMANT: John Wm. Crawford, Albert W.Va.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uremia	2 wks
DUE TO (b)	Carcinomatosis	1 yr
DUE TO (c)	Carcinoma prostate	2 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 177X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 18 Apr, 1960 to 19 Apr, 1960 that I last saw the deceased alive on 18 Apr, 1960, and that death occurred at 4:08 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew E Mance M.D.
ADDRESS (Street, city or town, state): Oakland Md
DATE SIGNED: 19 Apr 60

PHYSICIAN'S NAME (Type): Andrew E. Mance, M.D. Oakland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Apr. 21, 1960
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cem
22d. LOCATION (City, town, or county) (State): Thomas, West Va.

23. FUNERAL DIRECTOR'S SIGNATURE: W. D. Duncan
ADDRESS: Thomas, W.Va.

24a. REC'D BY REGISTRAR DATE: APR 22 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4589

CERTIFICATE OF DEATH

C4542
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY GARRETT MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL GRANTSVILLE
c. LENGTH OF STAY IN 1b LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XRURAL GRANTSVILLE
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First IDA Middle MAE Last DURST

4. DATE OF DEATH Month APRIL Day 24 Year 1960

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH UNKNOWN 1888

9. AGE (In years last birthday) 72 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY OWN HOME

11. BIRTHPLACE (State or foreign country) GARRETT Co MD

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Wm BITTINGER

14. MOTHER'S MAIDEN NAME EMMA SPEICKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

INFORMANT Address Mr Emmanuel Durst Grantsville RD #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart Disease

DUE TO (c) Generalized Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 12, 19 60 to April 23, 1960 that I last saw the deceased alive on April —, 19 —, and that death occurred at 10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Harold O. Kamons M.D. ADDRESS (Street, city or town, state) M.D. R.D. Markleysburg DATE SIGNED April 26

PHYSICIAN'S NAME (Type) HAROLD O. KAMONS

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 4/27/60

22c. NAME OF CEMETERY OR CREMATORY OAK GROVE

22d. LOCATION (City, town, or county) (State) RD #1 GRANTSVILLE GARRETT Co

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Don Newman, Grantsville, Md

24a. REC'D BY REGISTRAR DATE APR 29 '60

24b. REGISTRAR'S SIGNATURE Clinton S. Knous

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 64543

4590

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, nr. Frostburg
c LENGTH OF STAY IN 1b: years
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Star Route, Frostburg

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, nr. Frostburg
d. STREET ADDRESS: Star Route, Frostburg
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NORMAN Middle BERNARD Last DURST

4. DATE OF DEATH: Month April Day 6 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 23, 1909
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b KIND OF BUSINESS OR INDUSTRY: General Farming
11. BIRTHPLACE (State or foreign country): Sutton, Maryland
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Wesley Durst
14. MOTHER'S MAIDEN NAME: Sarah Catherine Layman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
INFORMANT: George Durst — Address: Star Route Frostburg, Maryland

I

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic glomerular nephritis, — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 592X
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arthritis
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a m p m 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from August 15, 1959, to April 6, 1960, that I last saw the deceased alive on April 5, 1960, and that death occurred at 7 ff M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H.C. Diehl M.D. ADDRESS (Street, city or town, state): Frostburg, Md. DATE SIGNED: 4/6/60

PHYSICIAN'S NAME (Type): H.C. DIEHL, M.D. FROSTBURG, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: April 8, 1960
22c. NAME OF CEMETERY OR CREMATORY: Zion Meth. Cemetery
22d. LOCATION (City, town, or county) (State): Long Stretch, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland
24a REC'D BY REGISTRAR DATE: APR 11 '60
24b. REGISTRAR'S SIGNATURE: Cathy S. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM II/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4591 Item 9 Filed 4-21-60 et 64544

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ACCIDENT MD
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ACCIDENT, MD
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MATILDA — Middle MARIE — Last ENGLEHART

4. DATE OF DEATH: Month APRIL — Day 9 — Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 14, 1872

9. AGE (In years last birthday): 88 89 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): ACCIDENT GARRETT Co

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE F ENGLEHART

14. MOTHER'S MAIDEN NAME: SUSAN DIEHL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs Harry Humberson — Address: Accident Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIORESPIRATORY FAILURE — INTERVAL BETWEEN ONSET AND DEATH:
420.0
DUE TO (b): Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Age.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from JAN, 1959, to Dec, 1959 that I last saw the deceased alive on Dec, 1959, and that death occurred at 2.30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Pedro Rivera M.D. — ADDRESS (Street, city or town, state): Box L-7 — DATE SIGNED:

PHYSICIAN'S NAME (Type): PEDRO RIVERA — Friendsville, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b DATE THEREOF: 4/11/60 — 22c. NAME OF CEMETERY OR CREMATORY: ZION LUTHERAN — 22d. LOCATION (City, town, or county) (State): ACCIDENT, GARRETT Co MD

23. FUNERAL DIRECTOR'S SIGNATURE: Don Mourman — ADDRESS: Grantsville, Md.

24a REC'D BY REGISTRAR DATE APR 18 '60 — 24b REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (4543)

CERTIFICATE OF DEATH

(4573) Reg. Dist. No. 16

1 PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b: 14 DAYS
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ROUTE # 2 BOX 124 SWANTON, MARYLAND
d STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

070

3. NAME OF DECEASED (Type or print): First BERTIE Middle Last ESHBAUGH

4. DATE OF DEATH: Month APRIL Day 8 Year 19 60

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]
8. DATE OF BIRTH: FEB. 3, 1903
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): GRANTSVILLE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: WILT, WILLIAM
14. MOTHER'S MAIDEN NAME: Mary ANN "WILT"

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16 SOCIAL SECURITY NO.
17. INFORMANT (NEIGHBOR) Address: HENRY E. FILSINGER

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 4 days

260 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b) Hypertensive Cardio Vascular disease — years

DUE TO (c) Diabetes Mellitus — 5 years

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Multiple Cerebral Vascular Accidents Old

19 WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1948, 19__, to 4-8, 19 60, that I last saw the deceased alive on 4-7, 19 60, and that death occurred at 5:17 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James H Feaster Jr. M.D. — ADDRESS (Street, city or town, state): 58 2nd St OAKLAND, Md — DATE SIGNED: 4-8-60

PHYSICIAN'S NAME (Type): DR. JAMES H. FEASTER JR. OAKLAND, MARYLAND

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/10/60
22c. NAME OF CEMETERY OR CREMATORY: Gastem Cem.
22d. LOCATION (City, town, or county) (State): Garrett Co. Md

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: E. J. Boal - Westernport, Md

24a. REC'D BY REGISTRAR DATE: APR 12 '60
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4550 **CERTIFICATE OF DEATH** 64546 Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ROUTE # 1 BOX 44 SWANTON, MARYLAND
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First ESTELLA — Middle ELIZABETH — Last FITZWATER

4. DATE OF DEATH: Month APRIL — Day 12 — Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 25, 1891

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: RECKNER, AMOS

14 MOTHER'S MAIDEN NAME: RUCKLE, ANNA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: ----

17 INFORMANT: HUSBAND — WILLIAM E. FITZWATER — Address: ROUTE 1 BOX 44 SWANTON, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, primary in breast — INTERVAL BETWEEN ONSET AND DEATH: 18 mos.

170X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 3/27, 1960, to 4/12, 1960, that I last saw the deceased alive on 4/12/60, 1960, and that death occurred at 9:20P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph Alvarez M.D — ADDRESS (Street, city or town, state): Oakland, Md. — DATE SIGNED: 4/13/60

PHYSICIAN'S NAME (Type): DR. JOSEPH ALVAREZ — OAKLAND, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/15/1960

22c. NAME OF CEMETERY OR CREMATORY: North Glade Cemetery

22d. LOCATION (City, town, or county) (State): near Swanton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: A. L. Leighton — ADDRESS: Oakland, Md.

24a REC'D BY REGISTRAR DATE APR 18 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

170x

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4592 — 04547 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL- KITZMILLER
c. LENGTH OF STAY IN 1b: 5yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PEERLESS - Paugh Mine
e. STREET ADDRESS: WATER ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KITZMILLER
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALLEN — Middle RAY — Last HARVEY
4. DATE OF DEATH: Month APRIL — Day 9 — Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct.20,1919
9. AGE (In years last birthday): 40 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner
10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines
11. BIRTHPLACE (State or foreign country): Garrett Co.,Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: RAY WILSON HARVEY
14. MOTHER'S MAIDEN NAME: ANNA D. McVICKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes, give war or dates of service): W.W.2
16. SOCIAL SECURITY NO.: 232-26-2354
17. INFORMANT — Address: Mrs. Mary Harvey,Kitzmiller, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Suffocation — INTERVAL BETWEEN ONSET AND DEATH: Minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 910.2
DUE TO (b): Multiple Head contusions — H
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Caught in rock slide while mining coal near Kitzmiller, Md.
20c. TIME OF INJURY — Hour 2 o'clock p. m. — Month, Day, Year 4-9 1960
20d. INJURY OCCURRED — While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Coal mine
20f. (City or town) (County) (State): Nr. Kitzmiller Garrett, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James H. Feaster Jr. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): James H. Feaster Jr., M. D.
DATE SIGNED: 4-10-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Apr.12/60
22c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery,
22d. LOCATION (City, town, or county) (State): Elk Garden,Mineral Co.,W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE: H.G. Leighton
ADDRESS: Oakland, Md.
24a. REC'D BY REGISTRAR — DATE APR 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

64548

4583 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b: 3 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Garrett County Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Oakland
d. STREET ADDRESS: 810 Liberty Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

070

3. NAME OF DECEASED (Type or print): First: May; Middle: Hammil; Last: Loraditch

4. DATE OF DEATH: Month: April; Day: 10; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12/10/1878

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Keyser, West Virginia

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Moses R. Hammil

14. MOTHER'S MAIDEN NAME: Margaret Doffart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Self — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 hours

DUE TO (b): Cerebro Vascular insufficiency — 1 yr

DUE TO (c): Arteriosclerosis — 1 yr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JANUARY 1, 1955, to April 10, 1960, that I last saw the deceased alive on April 10, 1960, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): Oakland Md DATE SIGNED: 4/13/60

PHYSICIAN'S NAME (Type): Dr. A. E. Mance — Oakland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-12-60

22c. NAME OF CEMETERY OR CREMATORY: Oakland Cem.

22d. LOCATION (City, town, or county) (State): Oakland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: Bennett Funeral Home, Oakland, Md

24a. REC'D BY REGISTRAR DATE: APR 13 '60

24b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

4593 — 64549 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Garrett — MARYLAND
b. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town) Rural-Westernport
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4 Mi. W. of Westernport

2. USUAL RESIDENCE (Where deceased lived. If institution Res dence before admission)
a. STATE Md. — b. COUNTY Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Westernport
d. STREET ADDRESS 1/4 Mi. W. Westernport
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print) First: Thomas — Middle: — Last: Magruder

4. DATE OF DEATH — Month: April — Day: 23 — Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 25, 1894
9. AGE (In years last birthday) 65 yrs.
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Magruder
14. MOTHER'S MAIDEN NAME: Hattie Micheal

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes. (If yes, give war or dates of service) W.W.1
16. SOCIAL SECURITY NO. 220-30-8712
INFORMANT — Address: Mrs. Flora Magruder-R.D.1 Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 8 years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour o. m. p. m.; 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 10, 1952, to Apr 23, 1960, that I last saw the deceased alive on Apr 8, 1960, and that death occurred at 11 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul R Wilson M.D. — ADDRESS (Street, city or town, state): 111 Ashbie Ld St. Piedmont, W.Va. — DATE SIGNED: 4-25-60
PHYSICIAN'S NAME (Type): Paul R. Wilson, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/27/60
22c. NAME OF CEMETERY OR CREMATORY: Philos
22d. LOCATION (City, town, or county) (State): Westernport Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E. L. Bevil — ADDRESS: Westernport, Md.
24a. REC'D BY REG STRAR DATE: APR 26 '60
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Fill for [illegible]

4552

CERTIFICATE OF DEATH

Reg. Dist. No. 04550

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible]
c. LENGTH OF STAY IN 1b: [illegible] yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: [illegible] Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: [illegible]
b. COUNTY: [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible]
d. STREET ADDRESS: [illegible]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First [illegible] Middle BERNARD Last [illegible]

4. DATE OF DEATH: Month 4 Day [illegible] Year 1960

5. SEX: [illegible]
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 22 1884
9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months [illegible] Days [illegible]
IF UNDER 24 HRS: Hours [illegible] Min [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: BARBER
11. BIRTHPLACE (State or foreign country): [illegible]
12. CITIZEN OF WHAT COUNTRY? [illegible]

13. FATHER'S NAME: [illegible] Carlyle
14. MOTHER'S MAIDEN NAME: unknown LAYMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): [illegible]
16. SOCIAL SECURITY NO: [illegible]
17. INFORMANT: Mrs Edna Frankenberry Address: Mt Savage Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Sclerotic Heart Disease — 4 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteritis Hypertonic
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-18 19[illegible], to 4-25 19[illegible], that I last saw the deceased alive on 4-25 19[illegible], and that death occurred at 3:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James H. Foster, Jr. M.D. ADDRESS (Street, city or town, state): 58 2-1 Oakland, Md. DATE SIGNED: 4 30 60

PHYSICIAN'S NAME (Type): James H. Foster, Jr. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): [illegible]
22b. DATE THEREOF: [illegible]
22c. NAME OF CEMETERY OR CREMATORY: [illegible]
22d. LOCATION (City, town, or county) (State): [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE: Don J Newman ADDRESS: Grantsville Md.
24a. REC'D BY REGISTRAR DATE: MAY 4 '60
24b. REGISTRAR'S SIGNATURE: Clinton J. Kuhn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4583 **CERTIFICATE OF DEATH** C4551

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eastland Dist
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Friendsville Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Md
b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Friendsville RFD
d. STREET ADDRESS: Home
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Estie Middle Last Nicholas

4. DATE OF DEATH: Month April Day 15th Year 1960

5. SEX: F

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1885 Oct 4th

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Samuel Vansickle

14. MOTHER'S MAIDEN NAME: Ella Vansickle Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Goldie Nichols Address: Friendsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Days

DUE TO (b): Myocardial Insufficiency — Years

DUE TO (c): Arteriosclerosis Generalized — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 8-18, 1953, to 4-15, 1960, that I last saw the deceased alive on 4-13, 1960, and that death occurred at 7:10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James H Jenster Jr M D

ADDRESS (Street, city or town, state): 58 East Oakland Ave

DATE SIGNED: 4.15.60

PHYSICIAN'S NAME (Type): James H Jenster Sr M D

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Apr-17-1960

22c. NAME OF CEMETERY OR CREMATORY: Sand Spring Cemetery

22d. LOCATION (City, town, or county) (State): Friendsville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Brockham Markley Jr

ADDRESS: Markleysburg Pa

24a. REC'D BY REGISTRAR DATE: APR 19 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Friend

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4594

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04552
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Garrett MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible] t l
c. LENGTH OF STAY IN 1b 60 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE [illegible] b. COUNTY [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Charles Middle: Clyde Last: O'Haver
4. DATE OF DEATH Month: 4 Day: 21 Year: 19 60
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/6/[illegible]
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or Foreign country): [illegible], W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph O'Haver
14. MOTHER'S MAIDEN NAME: [illegible]ers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: [illegible]-[illegible]-[illegible]
17. INFORMANT: C. O'Haver Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction, Acute — INTERVAL BETWEEN ONSET AND DEATH: Mins.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: a. m. p. m. Month, Day, Year: 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☒, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James H. Foster M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): James H. Foster, Jr., M. D.
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 4-21-60

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 4/24/60
22c. NAME OF CEMETERY OR CREMATORY: Taylor-Sines Cemetery
22d. LOCATION (City, town, or county) (State): Oakland [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Minnick Funeral Home [illegible]
24a. REC'D BY REGISTRAR DATE: APR 27 '60
24b. REGISTRAR'S SIGNATURE: Cathryn L. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4595 — Reg. Dist. No. 4553

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kitzmiller
c. LENGTH OF STAY IN 1b: 1 Week
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kitzmiller R.F.D
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
CHARLES	LEO	PAUGH	APRIL	9TH.	1960

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	NEVER MARRIED ☒	May 16, 1938	21 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner	Coal	W.Va	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph S. Paugh	Emily Evans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	212-38-5205	Joseph S. Paugh Kitzmiller, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Broken neck — INTERVAL BETWEEN ONSET AND DEATH: Immediate

110.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.): Caught in a rock slide in coal mine accident, near Kitzmiller, Md.

20c. TIME OF INJURY Hour / Month, Day, Year	20d. INJURY OCCURRED While at work ☒ / Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
2 Hour p. m. 4-9-60 19	While at work ☒	Coal mine	Kitzmiller Garrett Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James H. Feaster M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED

EXAMINER'S NAME (Type): James H. Feaster, Jr., M. D. — 4-9-60

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	4-12-60	I.O.O.F	Elk Garden W.Va

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Robert Kyle Pritt Jr. Kitzmiller, Md	APR 18 '60	Arthur S. Kuhn

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4554 Reg. Dist. No.

458E

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-KITZMILLER
c. LENGTH OF STAY IN 1b: 25 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PEERLESS - Paugh Mine

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL KITZMILLER
d. STREET ADDRESS: REERLESS HILL
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JOHN Middle LEROY Last PAUGH
4. DATE OF DEATH: Month APRIL Day 9 Year 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: July 3, 1909
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MINER
10b. KIND OF BUSINESS OR INDUSTRY: COAL MINES
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN HENRY PAUGH
14. MOTHER'S MAIDEN NAME: ANNA B. DISHONG

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-01-8038
17. INFORMANT: Mrs. Belva Paugh Address: Kitzmiller, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fractured Skull — INTERVAL BETWEEN ONSET AND DEATH: Immediate
910.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Caught in rock slide while mining coal near Kitzmiller, Md.
20c. TIME OF INJURY: Hour 2 p. m. Month, Day, Year 4-9-60 19
20d. INJURY OCCURRED While at work [X] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Coal Mine
20f. (City or town) Nr. Kitzmiller (County) Garrett (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and find that death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: Jas. H. Feaster Jr. M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
EXAMINER'S NAME (Type): James H. Feaster Jr., M. D.
DATE SIGNED: 4-10-60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 4/12/1960
22c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery
22d. LOCATION (City, town, or county) (State): Elk Garden, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: H. C. Leighton ADDRESS: Oakland, Md.
24a. REC'D BY REGISTRAR DATE APR 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kuns

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4597

CERTIFICATE OF DEATH

64555

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH — a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Westernport
c. LENGTH OF STAY IN 1b: 30 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) — a. STATE: Md. — b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural-Westernport
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Jackson — Middle: Howard — Last: Sears

4. DATE OF DEATH: Month: April — Day: 16 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 8, 1892

9. AGE (In years last birthday): 67 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): W.Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Sears

14. MOTHER'S MAIDEN NAME: Margaret Ann Urice

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Jackson Sears-R.D. 1 Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b):

DUE TO (c): Arteriosclerosis — 4 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Had resection Alaska

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1, 1957 to Apr 16 1960, that (I) (we) last saw the deceased alive on Apr 16, 1960 and that death occurred at 7 P.M., from the causes and on the date stated above.

22a. SIGNATURE: P E Berry M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: Apr. 18-60

22c. PHYSICIAN'S NAME (Type): P. E. Berry

22d. ADDRESS: Piedmont W. Va.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/19/60

23c. NAME OF CEMETERY OR CREMATORY: Philos

23d. LOCATION (City, town, or county) (State): Westernport Md.

24. FUNERAL DIRECTOR'S SIGNATURE: E. Beal — ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR — DATE: APR 19 '60

25b. REGISTRAR'S SIGNATURE: Clarkson S. Kinnaird

420.1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4584 **CERTIFICATE OF DEATH** C4556

Reg. Dist. No.

1. PLACE OF DEATH
a COUNTY GARRETT MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE MARYLAND b COUNTY GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X HUTTON
d STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First ALBERT Middle C. Last SEVERE

4. DATE OF DEATH Month APRIL Day 24 Year 19 60

5. SEX MALE
6. COLOR OR RACE WHITE
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH JULY 20, 1897
9. AGE (In years last birthday) 62 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER
10b. KIND OF BUSINESS OR INDUSTRY Coal Mines
11. BIRTHPLACE (State or foreign country) LENCX, W. VA.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME SEVERE, ELMER
14. MOTHER'S MAIDEN NAME WILHEIM, NANCY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 219-01-3189
17. INFORMANT WILLIAM B. SEVERE Address HUTTON, MARYLAND

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 3-5 years

DUE TO (b) Arteriosclerosis — 12 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c) Rheumatic heart chronic valvular disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/12/59 to 4/24/60 that I last saw the deceased alive on 4/24/60, and that death occurred at 10:48P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE A. E. Mance M.D.
ADDRESS (Street, city or town, state) 101 THIRD STREET
DATE SIGNED 4/25/60

PHYSICIAN'S NAME (Type) DR. A. E. MANCE OAKLAND, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial
22b. DATE THEREOF 4/27/60
22c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery
22d LOCATION (City, town, or county) (State) Terra Alta, West Virginia

23. FUNERAL DIRECTOR'S SIGNATURE [signature] ADDRESS Md. F.D. License A 7220 Terra Alta, W.Va.
24a REC'D BY REGISTRAR DATE APR 28 '60
24b. REGISTRAR'S SIGNATURE [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4595 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04557
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Garrett Co. Mem. Hosp. (Dead on arrival)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pa. — b. COUNTY: Fulton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harrisonville 75X-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Emmual — Last: Weaver
4. DATE OF DEATH: Month: April — Day: 6th — Year: 19 60

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-1-92
9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): dispatcher
10b. KIND OF BUSINESS OR INDUSTRY: Transportation
11. BIRTHPLACE (State or foreign country): Cambria, Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Adam Weaver
14. MOTHER'S MAIDEN NAME: Mary Webb

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 196-09-8950
17. INFORMANT: Mrs. Mary Deshong — Address: Johnstown, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured neck — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b): Fractured skull
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Driver of car which skidded and struck a truck on icy roads.
20c. TIME OF INJURY: 10:30 a. m. p. m. — Month, Day, Year: 4-6-60 — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): U. S. Rt. 50
20f. (City or town) (County) (State): Nr. Mt. Storm, W. Va. (Grant Co.)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James H. Feaster Jr. M.D.
EXAMINER'S NAME (Type): James H. Feaster, Jr., M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 4-6-60

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 4/9/60
22c. NAME OF CEMETERY OR CREMATORY: Mt. Hope Cemetery
22d. LOCATION (City, town, or county) (State): South Fork, Pa

23. FUNERAL DIRECTOR'S SIGNATURE: Gerald N. Minnich — ADDRESS: Oakland, Md.
24a. REC'D BY REGISTRAR DATE: APR 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

815X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

4598 — Reg. Dist. No. 1558

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Lake Park,
c. LENGTH OF STAY IN 1b: 40 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ---

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mt. Lake Park,
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: Calvin — Last: Winters

4. DATE OF DEATH: Month: April — Day: 3, — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 17, 1874

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer & Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Winters

14. MOTHER'S MAIDEN NAME: Martha Roth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss Hilda Winters — Address: Mt. Lake Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Melanoma — INTERVAL BETWEEN ONSET AND DEATH: 1½ mos
DUE TO
191.3
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Primary Malignant Melanoma face — 14 yrs
DUE TO
(c): Cerebro Sclerosis — 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/26/ 1957 to 4/3/ 1960 that I last saw the deceased alive on 4/1/ 1960, and that death occurred at 4:30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. E. Mance M.D. — ADDRESS (Street, city or town, state): 101 THIRD STREET — DATE SIGNED: 4/4/60

PHYSICIAN'S NAME (Type): Andrew E. Mance, M. D. — Oakland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/5/1960

22c. NAME OF CEMETERY OR CREMATORY: Texas Cemetery

22d. LOCATION (City, town, or county) (State): Preston County, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: H. C. Leighton — ADDRESS: Oakland, Md.

24a. REC'D BY REGISTRAR DATE: APR 7 '60

24b. REGISTRAR'S SIGNATURE: Oakland [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57